

## **PSYCHOSOCIAL ASPECTS OF CARE**

The emotional response of the patient during illness is of extreme importance. The mind-body-spirit connection is well established; it is known, for example, that when a physiological response occurs, there is a corresponding psychological response. Also, there are physiological conditions that have a psychological component, for example, the emotional instability associated with steroid therapy or Cushing's syndrome or the irritability of hypoglycemia. Rapid growth in the field of psychoneuroimmunology is regularly providing new information about these issues.

With expanding technology in healthcare, ethical issues are hotly debated. Although the stress of illness is well recognized, the effect on the individual is unpredictable. It is not necessarily the event that creates problems, but rather the patient's perception of and response to the event, which may result in unmet psychological needs that drain energy resources needed for healing. The caregivers', patients', and significant others' (SOs) values, sensitivity to different cultures, and language barriers (including difficulties that people have in talking about their bodies) affect the care a patient expects and receives.

### **CARE SETTING**

Any setting in which nursing contact occurs/care is provided.

### **RELATED CONCERNS**

This is an aspect of all care and plans of care.

## **Assessment Factors To Be Considered**

### **INDIVIDUAL**

Age and gender

Religious affiliation: Church attendance, importance of religion in patient's life, belief in life after death

Level of knowledge/education; how the individual accesses and incorporates information, i.e., auditory, visual, kinesthetic

Patient's dominant language/literacy; knowledge and use of other languages; style of speech

Patterns of communication with SOs, with healthcare givers

Perception of body and its functions: In health, illness, this illness

How does patient define and perceive illness?

How is patient experiencing illness versus what illness actually is?

Emotional response to current treatment/hospitalization

Past experience with illness, hospitalization, and healthcare systems

Emotional reactions in feeling (sensory) terms: e.g., states, "I feel scared"

Behavior when anxious, afraid, impatient, withdrawn, or angry

### **SIGNIFICANT OTHERS**

Marital status; SOs, nuclear family, extended family; recurring or patterned relationships

Family development cycle: Just married, children (young, adolescent, leaving/returning home), retired

What are the interaction processes within the family?

Patient's role in family tasks and functions

How are SOs affected by the illness and prognosis?

Lifestyle differences that need to be considered: Dietary, spiritual, sexual preference, other community (e.g., religious order, commune, retirement center)

### **SOCIOECONOMIC**

Employment; finances

Environmental factors: residence, work, and recreation; out of usual environment (on vacation, visiting)

Social class; value system

Social acceptability of disease/condition (e.g., sexually transmitted diseases [STDs], HIV, obesity, substance abuse)

### **CULTURAL**

Ethnic background; heritage and residence/locale

Beliefs regarding caring and curing

Health-seeking behaviors; illness referral system  
Values related to health and treatment  
Cultural factors related to illness in general and to pain response

### DISEASE (ILLNESS)

Kind/cause of illness; how has it been treated, how should it be treated? Anticipated response to treatment; patient's/SO's expectations  
Is this an acute or a chronic illness? Is it inherited? What is the threat to self/others?  
If terminal illness, what do patient and SO know and anticipate?  
Is the condition "appropriate" to the afflicted individual, e.g., multiple sclerosis, diabetes mellitus (DM), cancer?  
(*Note:* Some theories suggest certain personalities are prone to certain illnesses.)  
Illness related to personality factors, such as type A (may be myth or valid relative to management of stressors); high-risk behaviors

### NURSE-RELATED

Basic knowledge of human responses and how the current situation is related to response of the individual  
Basic knowledge of biological, psychological, social, and cultural issues  
Knowledge and use of therapeutic communication skills  
Knowledge of own value and belief systems, including prejudices, biases  
Willingness to look at own behavior in relation to interaction with others and make changes as necessary  
Respect of patient's privacy; confidentiality; human needs

### NURSING PRIORITIES

1. Reduce anxiety/fear.
2. Support grieving process.
3. Facilitate integration of self-concept and body-image changes.
4. Encourage effective coping skills of patient/SO.
5. Promote safe environment/patient well-being.

### DISCHARGE GOALS

1. Reports/anxiety/fear manageable.
2. Progressing through stages of grieving.
3. Patient/family dealing realistically with current situation.
4. Safe environment maintained.
5. Plan in place to meet needs after discharge.

**NURSING DIAGNOSIS: Anxiety [specify level]/Fear**

**May be related to**

Unconscious conflict about essential goals and values of life; unmet needs  
Situational/maturational crises; interpersonal transmission and contagion; stress  
Threat of death (perceived or actual)  
Threat to, or change in health status (progressive/debilitating disease, terminal illness); interaction patterns, role function/status, environment (safety), economic status  
Separation from support system; knowledge deficit  
Sensory impairment; environmental stimuli; substance abuse; stress

**Possibly evidenced by**

Reports of increased tension; feelings of helplessness; inadequacy; apprehension, uncertainty, being scared, overexcited  
Facial tension; sympathetic/parasympathetic stimulation (quivering voice, trembling, insomnia); extraneous movements (e.g., foot shuffling, hand/arm movements)  
Expressed concern regarding changes in life events; dread of an identifiable problem recognized by patient; fear of unspecified consequences  
Focus on self; fight/flight behavior

**DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:**

**Anxiety [or] Fear Control (NOC)**

Acknowledge and discuss fears/concerns.  
Appear relaxed and report anxiety is reduced to a manageable level.  
Verbalize awareness of feelings of anxiety and healthy ways to deal with them.  
Demonstrate problem solving and use resources effectively.

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Anxiety Reduction (NIC)</b></p> <p><b>Independent</b></p> <p>Note palpitations, elevated pulse/respiratory rate.</p> <p>Acknowledge fear/anxieties. Validate observations with patient, e.g., “You seem to be afraid.”</p> <p>Assess degree/reality of threat to patient and level of anxiety (e.g., mild, moderate, severe) by observing behavior such as clenched hands, wide eyes, startle response, furrowed brow, clinging to family/staff, or physical/verbal lashing out.</p> <p>Note narrowed focus of attention (e.g., patient concentrates on one thing at a time).</p> <p>Observe speech content, vocabulary, and communication patterns, e.g., rapid/slow, pressured speech; words commonly used, repetition, use of humor/laughter, swearing.</p>	<p>Changes in vital signs may suggest the degree of anxiety patient is experiencing or reflect the impact of physiological factors, e.g., endocrine imbalances, medications.</p> <p>Feelings are real, and it is helpful to bring them out in the open so they can be discussed and dealt with.</p> <p>Individual responses can vary according to cultural beliefs/traditions and culturally learned patterns. Distorted perceptions of the situation may magnify feelings.</p> <p>Narrowed focus usually reflects extreme fear/panic.</p> <p>Provides clues about such factors as the level of anxiety, ability to comprehend what is currently happening, cognition difficulties, and possible language differences.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Anxiety Reduction (NIC)</b></p> <p><b>Independent</b></p> <p>Assess severity of pain when present. Delay gathering of information if pain is severe.</p> <p>Identify patient's/SO's perception(s) of the situation.</p> <p>Acknowledge reality of the situation as patient sees it, without challenging the belief.</p> <p>Evaluate coping/defense mechanisms being used to deal with the perceived or real threat.</p> <p>Review coping mechanisms used in the past, e.g., problem-solving skills, recognizing/asking for help.</p> <p>Assist patient to use the energy of anxiety for coping with the situation when possible.</p> <p>Maintain frequent contact with patient/SO. Be available for listening and talking as needed.</p> <p>Acknowledge feelings as expressed (e.g., use of Active-Listening, reflection). If actions are unacceptable, take necessary steps to control/deal with behavior. (Refer to ND: Violence, risk for.)</p> <p>Identify ways in which patient can get help when needed, including telephone numbers of contact persons.</p> <p>Stay with or arrange to have someone stay with patient as indicated.</p> <p>Provide accurate information as appropriate and when requested by patient/SO. Answer questions freely and honestly and in language that is understandable by all. Repeat information as necessary; correct misconceptions.</p> <p>Avoid empty reassurances, with statements of "everything will be all right." Instead, provide specific information: e.g., "Your heart rate is regular, your pain is being easily controlled, and that is what we want," or "Your CD4 count has been stable for the last three visits."</p>	<p>Severe pain and anxiety leave little energy for thinking and other activities.</p> <p>Regardless of the reality of the situation, perception affects how each individual deals with the illness/stress.</p> <p>Patient may need to deny reality until ready to deal with it. It is not helpful to force patient to face facts.</p> <p>May be dealing well with the situation at the moment; e.g., denial and regression may be helpful coping mechanisms for a time. However, continued use of such mechanisms diverts energy patient needs for healing, and problems need to be dealt with at some point in time.</p> <p>Provides opportunity to build on resources patient/SO may have used successfully.</p> <p>Moderate anxiety heightens awareness and can help motivate patient to focus on dealing with problems.</p> <p>Establishes rapport, promotes expression of feelings, and helps patient and SO look at realities of the illness/treatment without confronting issues they are not ready to deal with.</p> <p>Often acknowledging feelings enables patient to deal more appropriately with situation. May need chemical/physical control for brief periods.</p> <p>Provides assurance that staff/resources are available for assistance/support.</p> <p>Continuous support may help patient regain internal locus of control and reduce anxiety/fear to a manageable level.</p> <p>Complex and/or anxiety-provoking information can be given in manageable amounts over an extended period. As opportunities arise and facts are given, individuals will accept what they are ready for. <i>Note:</i> Words/phrases may have different meanings for each individual; therefore, clarification is necessary to ensure understanding.</p> <p>It is not possible for the nurse to know how the specific situation will be resolved, and false reassurances may be interpreted as lack of understanding or honesty, further isolating patient. Sharing observations used in assessing condition/prognosis provides opportunity for patient/SO to feel reassured.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Anxiety Reduction (NIC)</b></p> <p><b>Independent</b></p> <p>Note expressions of concern/anger about treatment or staff.</p> <p>Ask patient/SO to identify what he or she can/cannot do about what is happening.</p> <p>Provide as much order and predictability as possible in scheduling care/activities, visitors.</p> <p>Instruct in ways to use positive self-talk, e.g., “I can manage this pain for now,” or “My cancer is shrinking.”</p> <p>Encourage patient to develop regular exercise/activity program.</p> <p>Encourage/instruct in guided imagery/relaxation techniques; e.g., imaging a pleasant place, use of music/tapes, deep-breathing, meditation, and mindfulness.</p> <p>Provide touch, Therapeutic Touch, massage, and other adjunctive therapies as indicated.</p>	<p>Anxiety about self and outcome may be masked by comments or angry outbursts directed at therapy/caregivers.</p> <p>Assists in identifying areas in which control can be exercised and those in which control is not possible.</p> <p>Helps patient anticipate and prepare for difficult treatments/movements, as well as look forward to pleasant occurrences.</p> <p>Internal dialogue is often negative. When this is shared out loud, patient becomes aware and can be directed in the use of positive self-talk, which can help reduce anxiety.</p> <p>Helpful in reducing level of anxiety; has been shown to raise endorphin levels to enhance sense of well-being.</p> <p>Promotes release of endorphins and aids in developing internal locus of control, reducing anxiety. May enhance coping skills, allowing body to go about its work of healing. <i>Note:</i> Mindfulness is a method of being in the here and now, concentrating on what is happening in the moment.</p> <p>Aids in meeting basic human need, decreasing sense of isolation, and assisting patient to feel less anxious. <i>Note:</i> Therapeutic Touch requires the nurse to have specific knowledge and experience to use the hands to correct energy field disturbances by redirecting human energies to help or heal.</p>
<p><b>Collaborative</b></p> <p>Administer medications as needed: e.g., diazepam (Valium), clorazepate (Tranxene), chlordiazepoxide (Librium), alprazolam (Xanax), buspirone (BuSpar), oxazepam (Serax), lorazepam (Ativan), doxepin (Sinequan), fluoxetine (Prozac), sertraline (Zoloft).</p>	<p>Antianxiety agents and/or antidepressants may be useful for brief periods to assist patient/SO to reduce anxiety to manageable levels, providing opportunity for initiation of patient’s own coping skills. <i>Note:</i> Use of selective serotonin reuptake inhibitors (SSRIs) such as Prozac, Zoloft has been associated with sexual function complaints. Alternatives may need to be considered. Also, ethnic variations affecting psychotropic drugs require close monitoring to determine therapeutic dosage. For example, East Asians and blacks may be more sensitive/react faster, have higher plasma drug levels, and have increased risk of side effects, necessitating lower dosage than whites in general.</p>

**NURSING DIAGNOSIS: Grieving [specify]**

**May be related to**

Actual or perceived object loss (may include people, possessions, job, status, home, ideals, parts and processes of the body); chronic and/or fatal illness

Thwarted grieving response to a loss; lack of resolution of previous grieving response/absence of anticipatory grieving

**Possibly evidenced by**

Verbal expression of distress/unresolved issues, difficulty in expressing loss; denial of loss

Altered eating habits, sleep/dream patterns, activity levels, libido

Crying; labile affect; feelings of sorrow, guilt, anger

Alterations in concentration and/or pursuit of tasks, developmental regression; difficulty taking on new or different roles

**DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:**

**Grief Resolution (NOC)**

Identify and express feelings freely/effectively.

Verbalize a sense of progress toward resolution of the grief and hope for the future.

Function at an adequate level, participate in work and activities of daily living (ADLs), as appropriate.

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Grief Work Facilitation (NIC)</b></p> <p><b>Independent</b></p> <p>Provide open environment in which patient feels free to realistically discuss feelings and concerns.</p> <p>Determine patient perception and meaning of loss (current and past). Note cultural factors/expectations.</p> <p>Identify stage of grieving and effect on functioning:</p> <p><b>Denial:</b> Be aware of avoidance behaviors: anger, withdrawal, and so forth. Allow patient to talk about what he or she chooses, and do not try to force patient to “face the facts”;</p> <p><b>Anger:</b> Note behaviors of withdrawal, lack of cooperation, and direct expression of anger. Be alert to body language and check meaning with patient, noting congruency with verbalizations. Encourage/allow verbalization of anger, acknowledge feelings, set limits regarding destructive behavior;</p>	<p>Therapeutic communication skills such as Active-Listening, silence, being available, and acceptance provide opportunity and encourage patient to talk freely and deal with the perceived/actual loss.</p> <p>Affects patient’s responses and needs to be acknowledged in planning care.</p> <p>Awareness allows for appropriate choice of interventions because individuals handle grief in many different ways.</p> <p>Denying the reality of diagnosis and/or prognosis is an important phase in which patient protects self from the pain and reality of the threat of loss. Each person does this in an individual manner based on previous experiences with loss and cultural/religious factors.</p> <p>Denial gives way to feelings of anger, rage, guilt, and resentment. Patient may find it difficult to express anger directly and may feel guilty about normal feelings of anger. Although staff may have difficulty dealing with angry behaviors, acceptance allows patient to work through the anger and move on to more effective coping behaviors.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Grief Work Facilitation (NIC)</b></p>	
<p><b>Independent</b></p>	
<p><b>Bargaining:</b> Be aware of statements such as “. . . if I do this, my problem will be fixed.” Allow verbalization without confrontation about realities;</p>	<p>Bargaining with care providers or God often occurs and may be helpful in beginning resolution and acceptance. Patient may be working through feelings of guilt about things done or undone.</p>
<p><b>Depression:</b> Give patient permission to be where he or she is. Provide hope within parameters of individual situation without giving false reassurance. Provide comfort and availability, as well as caring for physical needs;</p>	<p>When patient can no longer deny the reality of the loss, feelings of helplessness and hopelessness replace feelings of anger. Patient needs information that this is a normal progression of feelings.</p>
<p><b>Acceptance:</b> Respect patient’s needs and wishes for quiet, privacy, and/or talking.</p>	<p>Having worked through the denial, anger, and depression, patient often prefers to be alone and does not want to talk much at this point. Patient may still cling to hope, which can be sustaining through whatever is happening at this point.</p>
<p>Active-Listen patient’s concerns and be available for help as necessary.</p>	<p>The process of grieving does not proceed in an orderly fashion, but fluctuates with various aspects of all stages present at one time or another. If process is dysfunctional or prolonged, more aggressive interventions may be required to facilitate the process.</p>
<p>Determine quality of interactions with others, including family members.</p>	<p>Although periods of withdrawal/loneliness usually accompany grieving, persistent isolation may indicate deepening depression, necessitating further evaluation/intervention. <i>Note:</i> Family/SO may not be dysfunctional but may be intolerant of patient’s behaviors.</p>
<p>Identify and problem-solve solutions to existing physical responses, e.g., eating, sleeping, activity levels, and sexual desire.</p>	<p>May need additional assistance to deal with the physical aspects of grieving.</p>
<p>Assess needs of SO and assist as indicated.</p>	<p>Identification of problems indicating dysfunctional grieving allows for individual interventions.</p>
<p>Include family/SO as appropriate when determining future needs.</p>	<p>Depending on patient desires/legal requirements, choices regarding future plans (e.g., living situation, continuation of care, end-of-life decisions, funeral arrangements) can provide guidance and peace of mind.</p>
<p>Discuss healthy ways of dealing with difficult situation.</p>	<p>Provides opportunity to look toward the future and plan family’s/SO’s needs (e.g., for life after loss).</p>
<p><b>Collaborative</b></p>	
<p>Refer to other resources, e.g., support groups, counseling, spiritual/pastoral care, psychotherapy as indicated.</p>	<p>May need additional help to resolve grief, make plans, and look toward the future.</p>

**NURSING DIAGNOSIS: Self-Esteem, situational low**

**May be related to**

Biophysical, psychosocial, cognitive, perceptual, cultural, and/or spiritual crisis, e.g., changes in health status/body image, role performance, personal identity; loss of control of some aspect of life  
Maturational transitions  
Perceived/anticipated failure at life event(s)

**Possibly evidenced by**

Rationalizes away/rejects positive feedback; negative self-appraisal in response to life events  
Verbalization of negative feelings about the self (helplessness, uselessness); focus on past abilities, strengths, function or appearance; preoccupation with change/loss  
Evaluates self as unable to handle situations/events; hesitant to try new things/situations; difficulty making decisions  
Fear of rejection/reaction by others; projection of blame/responsibility for problems

**DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:**

**Self-Esteem (NOC)**

Verbalize realistic view and acceptance of self in situation.  
Identify existing strengths and view self as capable person.  
Recognize and incorporate change into self-concept in accurate manner without negating self-worth.  
Demonstrate adaptation to changes/events that have occurred as evidenced by setting of realistic goals and active participation in work/play/personal relationships.

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Self-Esteem Enhancement (NIC)</b></p> <p><b>Independent</b></p> <p>Ask what patient would like to be called.</p> <p>Identify SO from whom patient derives comfort and who should be notified in case of emergency.</p> <p>Identify basic sense of self-esteem, image patient has of existential, physical, psychological self. Identify locus of control.</p> <p>Determine patient perception of threat to self.</p> <p>Active-Listen patient concerns and fears.</p>	<p>Shows courtesy/respect and acknowledges person.</p> <p>Allows provisions to be made for specific person(s) to visit or remain close, and provides needed support for patient. <i>Note:</i> May or may not be legal next of kin.</p> <p>May provide insight into whether this is a single episode or recurrent/chronic situation and can help determine needs and treatment plan. It is helpful to know whether the individual's locus of control is internal or external to provide most helpful interventions.</p> <p>Patient's perception is more important than what is really happening and needs to be dealt with before reality can be addressed.</p> <p>Conveys sense of caring and can be helpful in identifying patient's needs, problems, and coping strategies and how effective they are. Provides opportunity to duplicate and begin a problem-solving process.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Self-Esteem Enhancement (NIC)</b></p> <p><b>Independent</b></p> <p>Encourage verbalization of feelings, accepting what is said.</p> <p>Discuss stages of grief and the importance of grief work. (Refer to ND: Grieving [specify].)</p> <p>Provide nonthreatening environment, listen and accept patient as presented.</p> <p>Observe nonverbal communication, e.g., body posture and movements, eye contact, gestures, use of touch.</p> <p>Reflect back to patient what has been said, e.g., “it upset you when he told you that.”</p> <p>Observe and describe behavior in objective terms.</p> <p>Identify age and developmental level.</p> <p>Discuss patient’s view of body image and how illness/condition might affect it.</p> <p>Encourage discussion of physical changes in a simple, direct, and factual manner. Give realistic feedback and discuss future options, e.g., rehabilitation services.</p> <p>Acknowledge efforts at problem solving, resolution of current situation, and future planning.</p>	<p>Helps patient/SO begin to adapt to change, and reduces anxiety about altered function/lifestyle.</p> <p>Grieving is a necessary step for integration of change/loss into self-concept.</p> <p>Promotes feelings of safety, encouraging verbalization.</p> <p>Nonverbal language is a large portion of communication and therefore is extremely important. How the person uses touch provides information about how it is accepted and how comfortable the individual is with being touched.</p> <p>Clarification and verification of what has been heard promotes understanding and allows patient to validate information, otherwise assumptions may be inaccurate.</p> <p>All behavior has meaning, some of which is obvious and some of which needs to be identified. This is a process of educated guesswork and requires validation by patient.</p> <p>Age is an indicator of the stage of life patient is experiencing, e.g., adolescence, middle age. However, developmental level may be more important than chronological age in anticipating and identifying some of patient’s needs. Some degree of regression occurs during illness, depending on many factors such as the normal coping skills of the individual, the severity of the illness, and family/cultural expectations.</p> <p>Patient’s perception of a change in body image may occur suddenly or over time (e.g., actual loss of a body part through injury/surgery, or a perceived loss, such as a heart attack) or be a continuous subtle process (e.g., chronic illness, eating disorders, or aging). Awareness can alert the nurse to the need for appropriate interventions tailored to the individual need.</p> <p>Provides opportunity to begin incorporating actual changes in an accepting and hopeful atmosphere.</p> <p>Provides encouragement and reinforces continuation of desired behaviors.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Self-Esteem Enhancement (NIC)</b></p> <p><b>Independent</b></p> <p>Recognize patient's pace for adaptation to demands of current situation.</p> <p>Introduce tasks at patient's level of functioning, progressing to more complex activities as tolerated.</p> <p>Ascertain how patient sees own role within the family system, e.g., breadwinner, homemaker, husband/wife.</p> <p>Assist patient/SO with clarifying expected roles and those that may need to be relinquished or altered.</p> <p>Determine patient awareness of own responsibility for dealing with situation, personal growth.</p> <p>Assess impact of illness/surgery on sexuality.</p> <p>Be alert to comments and innuendos, which may mean patient has a concern in the area of sexuality.</p> <p>Be aware of caregiver's feelings about dealing with the subject of sexuality.</p>	<p>Failure to acknowledge patient's need to take time and/or pressuring patient to "get on with it" conveys a lack of acceptance of the person as an individual and may result in feelings of lowered self-esteem.</p> <p>Provides opportunity for patient to experience successes, reaffirming capabilities and enhancing self-esteem.</p> <p>Illness may create a temporary or permanent problem in role expectations. Sexual role and how patient views self in relation to the current illness also play important parts in recovery.</p> <p>Provides opportunity to identify misconceptions and begin to look at options; promotes reality orientation.</p> <p>Conveys confidence in patient's ability to cope. When patient acknowledges own part in planning and carrying out treatment plan, he or she has more investment in following through on decisions that have been made.</p> <p>Sexuality encompasses the whole person in the total environment. Many times problems of illness are superimposed on already existing problems of sexuality and can affect patient's sense of self-worth. Some problems are more obvious than others, such as illness involving the reproductive parts of the body. Others are less obvious, such as sexual values, role in family, e.g., mother, wage earner, single parent.</p> <p>People are often reluctant and/or embarrassed to ask direct questions about sexual/sexuality concerns.</p> <p>Nurses/caregivers are often as reluctant and embarrassed in dealing with sexuality issues as most patients. (Refer to CP: Extended Care, ND: Sexuality Patterns, ineffective/Sexual dysfunction, CD-ROM.)</p>
<p><b>Collaborative</b></p> <p>Provide information and referral to hospital and community resources.</p> <p>Support participation in group/community activities, e.g., assertiveness classes, volunteer work, support groups.</p>	<p>Enables patient/SO to be in contact with interested groups with access to assistive and supportive devices, services, and counseling.</p> <p>Promotes skills of coping and sense of self-worth.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Self-Esteem Enhancement (NIC)</b></p> <p><b>Collaborative</b></p> <p>Refer to psychiatric support/therapy group, social services, as indicated.</p> <p>Refer to appropriate resources for sex therapy as need indicates.</p>	<p>May be needed to assist patient/SO to achieve optimal recovery.</p> <p>May be someone with comfort level and knowledge who is available, or may be necessary to refer to professional resources for additional help and support.</p>

<p><b>NURSING DIAGNOSIS: Coping, ineffective/Decisional Conflict</b></p> <p><b>May be related to</b></p> <p>Situational crises/personal vulnerability; multiple life changes/maturational crises, age/developmental stage  Inadequate level of confidence in ability to cope, perception of control; high degree of threat; support  No vacations/inadequate relaxation  Impairment of nervous system; memory loss; impaired adaptive behaviors and problem-solving skills  Severe pain/overwhelming threat to self  Unclear personal values/beliefs; perceived threat to value system; lack of experience/interference with decision making; lack of information</p> <p><b>Possibly evidenced by</b></p> <p>Verbalization of inability to cope/ask for help; inappropriate use of defense mechanisms; inability to meet role expectations, basic needs, problem-solve  Muscular tension, frequent headaches/neck aches  Report of chronic worry, fatigue, insomnia, anxiety/depression; poor concentration  Poor self-esteem  Alteration in social participation; change in usual communication patterns; verbal manipulation  High illness/accident rate; overeating; excessive smoking/drinking  Destructive behavior toward self or others, risk-taking  Uncertainty about choices; vacillation between alternative actions; delayed decision making</p> <p><b>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</b></p> <p><b>Coping (NOC)</b></p> <p>Identify ineffective coping behaviors and consequences.  Verbalize awareness of own coping/problem-solving abilities.  Meet psychological needs as evidenced by appropriate expression of feelings, identification of options, and use of resources.</p> <p><b>Decision Making (NOC)</b></p> <p>Make decisions and express satisfaction with choices.</p>
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ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Coping Enhancement (NIC)</b></p> <p><b>Independent</b></p> <p>Review pathophysiology affecting patient and extent of feelings of hopelessness/helplessness/loss of control over life, level of anxiety; perception of situation.</p> <p>Establish therapeutic nurse-patient relationship.</p> <p>Note expressions of indecision, dependence on others, and inability to manage own ADLs.</p> <p>Assess presence of positive coping skills/inner strengths, e.g., use of relaxation techniques, willingness to express feelings, use of support systems.</p> <p>Encourage patient to talk about what is happening at this time and what has occurred to precipitate feelings of helplessness and anxiety.</p> <p>Evaluate ability to understand events. Correct misperceptions, provide factual information.</p> <p>Provide quiet, nonstimulating environment. Determine what patient needs, and provide if possible. Give simple, factual information about what patient can expect and repeat as necessary.</p> <p>Allow patient to be dependent in the beginning, with gradual resumption of independence in ADLs, self-care, and other activities. Make opportunities for patient to make simple decisions about care/other activities when possible, accepting choice not to do so.</p> <p>Accept verbal expressions of anger, setting limits on maladaptive behavior.</p>	<p>Indicators of degree of disequilibrium and need for intervention to prevent or resolve the crisis. Studies suggest that up to 85% of all physically ill people are depressed to some degree. Impairment of normal functioning for more than 2 wk, especially in presence of chronic condition, may reflect depression, requiring further evaluation.</p> <p>Patient may feel freer in the context of this relationship to verbalize feelings of helplessness/powerlessness and to discuss changes that may be necessary in patient's life.</p> <p>May indicate need to lean on others for a time. Early recognition and intervention can help patient regain equilibrium.</p> <p>When the individual has coping skills that have been successful in the past, they may be used in the current situation to relieve tension and preserve the individual's sense of control. However, limitations of condition may impact choices available to patient; e.g., playing musical instrument to relieve stress may not be possible for individual with tremors or hemiparesis, but listening to tapes/CDs may provide some degree of comfort.</p> <p>Provides clues to assist patient to develop coping and regain equilibrium.</p> <p>Assists in identification and correction of perception of reality and enables problem solving to begin.</p> <p>Decreases anxiety and provides control for patient during crisis situation.</p> <p>Promotes feelings of security (patient will know nurse will provide safety). As control is regained, patient has the opportunity to develop adaptive coping/problem-solving skills.</p> <p>Verbalizing angry feelings is an important process for resolution of grief and loss. However, preventing destructive actions (such as striking out at others) preserves patient's self-esteem.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Coping Enhancement (NIC)</b></p> <p><b>Independent</b></p> <p>Discuss feelings of self-blame/projection of blame on others.</p> <p>Note expressions of inability to find meaning in life/reason for living, feelings of futility or alienation from God.</p> <p>Promote safe and hopeful environment, as needed. Identify positive aspects of this experience and assist patient to view it as a learning opportunity.</p> <p>Provide support for patient to problem-solve solutions for current situation. Provide information and reinforce reality as patient begins to ask questions; look at what is happening.</p> <p>Provide for gradual implementation and continuation of necessary behavior and lifestyle changes. Reinforce positive adaptation/new coping behaviors.</p> <p><b>Collaborative</b></p> <p>Refer to other resources as necessary (e.g., clergy, psychiatric clinical nurse specialist/psychiatrist, family/marital therapist, addiction support groups).</p>	<p>Although these mechanisms may be protective at the moment of crisis, they eventually are counterproductive and intensify feelings of helplessness and hopelessness.</p> <p>Crisis situation may evoke questioning of spiritual beliefs, affecting ability to cope with current situation and plan for the future.</p> <p>May be helpful while patient regains inner control. The ability to learn from the current situation can provide skills for moving forward.</p> <p>Helping patient/SO to brainstorm possible solutions (giving consideration to the pros and cons of each) promotes feelings of self-control/esteem.</p> <p>Reduces anxiety of sudden change and allows for developing new and creative solutions.</p> <p>Additional assistance may be needed to help patient resolve problems/make decisions.</p>

<p><b>NURSING DIAGNOSIS: Family Coping, ineffective: risk for compromised</b></p> <p><b>Risk factors may include</b></p> <p>Inadequate or incorrect information or understanding by a primary person; unrealistic expectations</p> <p>Temporary family disorganization and role changes; feel that caregiving interferes with other important roles in their lives</p> <p>Prolonged disease/disability progression that exhausts the supportive capacity of family members</p> <p><b>Possibly evidenced by</b></p> <p>[Not applicable; presence of signs and symptoms establishes an <i>actual</i> diagnosis.]</p> <p><b>DESIRED OUTCOMES/EVALUATION CRITERIA—FAMILY WILL:</b></p> <p><b>Family Coping (NOC)</b></p> <p>Identify resources within themselves to deal with situation.</p> <p>Visit regularly and participate positively in care of patient, within limits of abilities.</p> <p>Express more realistic understanding and expectations of patient.</p> <p>Provide opportunity for patient to deal with situation in own way.</p>
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ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Family Involvement Promotion (NIC)</b></p> <p><b>Independent</b></p> <p>Establish rapport and acknowledge difficulty of the situation for family.</p> <p>Determine current knowledge/perception of the situation.</p> <p>Assess level of anxiety present in family/SO.</p> <p>Evaluate pre-illness/current behaviors that may be interfering with the care/recovery of patient.</p> <p>Discuss underlying reasons for patient behaviors with family.</p> <p>Assist family/patient to understand “who owns the problem” and who is responsible for resolution. Avoid placing blame or guilt.</p> <p>Reframe negative expressions into positives whenever possible.</p> <p>Involve family in information giving, problem solving, and care of patient as feasible. Identify other ways of demonstrating support while maintaining patient’s independence.</p>	<p>May assist family to accept what is happening and be willing to share problems with caregivers.</p> <p>Lack of information or unrealistic perceptions can interfere with family members’/patient’s response to illness situation.</p> <p>Anxiety level needs to be dealt with before problem solving can begin. Individuals may be so preoccupied with own reactions to situation that they are unable to respond to another’s needs.</p> <p>Information about family problems (e.g., divorce/separation, financial limitations, substance use) will be helpful in determining options and developing an appropriate plan of care.</p> <p>When family members know why patient is behaving in different ways, it helps them understand and accept/deal with situation.</p> <p>When these boundaries are defined, each individual can begin to take care of own self and stop taking care of others in inappropriate ways.</p> <p>Promotes more hopeful attitude and helps family/patient look toward the future.</p> <p>Information can reduce feelings of helplessness. Involvement in care enhances feelings of control and self-worth.</p>
<p><b>Collaborative</b></p> <p>Refer to appropriate resources for assistance as indicated (e.g., counseling, psychotherapy, financial, spiritual).</p>	<p>May need additional assistance in resolving family issues.</p>

**NURSING DIAGNOSIS: Family Coping: readiness for enhanced**

**May be related to**

Basic needs sufficiently gratified and adaptive tasks effectively addressed to enable goals of self-actualization to surface

Willingness to deal with one's own needs and to begin to problem-solve with patient

**Possibly evidenced by**

Family member attempting to describe growth impact of crisis on his/her own values, priorities, goals, or relationships

Family member moving in direction of health-promoting and enriching lifestyle and generally choosing experiences that optimize wellness

**DESIRED OUTCOMES/EVALUATION CRITERIA—FAMILY WILL:**

**Family Functioning (NOC)**

Express willingness to look at own role in family's growth.

Undertake tasks leading to change.

Verbalize feelings of self-confidence and satisfaction with progress being made.

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Family Support (NIC)</b></p>	
<p><b>Independent</b></p>	
<p>Provide opportunities for family to talk with patient and/or caregiver(s).</p>	<p>Reduces anxiety and allows expression of what has been learned and how they are managing, as well as opportunity to make plans for the future and share support.</p>
<p>Listen to family's expressions of hope, planning, effect on relationships/life, change of values.</p>	<p>Provides clues to avenues to explore for assistance with growth.</p>
<p>Provide opportunities for and instruction in how SOs can care for patient. Discuss ways in which they can support patient in meeting own needs.</p>	<p>Enhances feelings of control and involvement in situation in which SOs cannot do many things. Also provides opportunity to learn how to be most helpful when patient is discharged from care.</p>
<p>Provide a role model with which family may identify.</p>	<p>Having a positive example can help with adoption of new behaviors to promote growth.</p>
<p>Discuss importance of open communication. Role-play effective communication skills of Active-Listening, "I-messages," and problem solving.</p>	<p>Helps individuals to express needs and wants in ways that will develop family cohesiveness. Promotes solutions in which everyone wins.</p>
<p>Encourage family to learn new and effective ways of dealing with feelings.</p>	<p>Effective recognition and expression of feelings clarify situation for involved individuals.</p>
<p>Encourage seeking help appropriately. Give information about available persons and agencies.</p>	<p>Permission to seek help as needed allows them to choose to take advantage of available assistance/resources.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Family Support (NIC)</b></p> <p><b>Collaborative</b></p> <p>Refer to specific support group(s) as indicated.</p>	<p>Provides opportunities for sharing experiences; provides mutual support and practical problem solving; and can aid in decreasing alienation and helplessness.</p>

<p><b>NURSING DIAGNOSIS: Therapeutic Regimen: risk for ineffective management</b></p> <p><b>Risk factors may include</b></p> <p>Complexity of therapeutic regimen; knowledge deficits</p> <p>Decisional conflict: patient value system, health beliefs, spiritual values, cultural influences, ethical concerns</p> <p>Perceived barriers; economic difficulties; side effects of therapy; mistrust of regimen and/or healthcare personnel; complexity of healthcare system</p> <p>Family patterns of healthcare; family conflict</p> <p><b>Possibly evidenced by</b></p> <p>[Not applicable; presence of signs and symptoms establishes an <i>actual</i> diagnosis.]</p> <p><b>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</b></p> <p><b>Treatment Behavior: Illness or Injury (NOC)</b></p> <p>Participate in the development of goals and treatment plan.</p> <p>Verbalize accurate knowledge of disease and understanding of treatment regimen.</p> <p>Demonstrate behaviors/changes in lifestyle necessary to maintain therapeutic regimen.</p> <p>Identify/use available resources.</p>
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ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Values Clarification (NIC)</b></p> <p><b>Independent</b></p> <p>Review patient's/SO's knowledge and understanding of the need for treatment/medication, as well as consequences of actions and choices. Note ability to comprehend information, including literacy, level of education, primary language.</p> <p>Be aware of developmental and chronological age.</p> <p>Determine cultural, spiritual, and health beliefs and ethical concerns.</p>	<p>Provides opportunities to clarify viewpoints/misconceptions. Verifies that patient/SO has accurate/factual information with which to make informed choices.</p> <p>Impacts ability to understand own needs/incorporate into treatment regimen.</p> <p>Provides insight into thoughts/factors related to individual situation. Beliefs will affect patient's perception of situation and participation in treatment regimen. Treatment may be incongruent with patient's social/cultural lifestyle and perceived role/responsibilities.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Self-Modification Assistance (NIC)</b></p>	
<p><b>Independent</b></p>	
<p>Review treatment plan with patient/SO.</p>	<p>Provides opportunities to exchange accurate information and to clarify viewpoints/misconceptions.</p>
<p>Contract with patient for participation in care.</p>	<p>Patient who agrees to own responsibility is more apt to adhere to treatment plan.</p>
<p>Establish graduated goals or modified regimen as necessary; work out alternative solutions.</p>	<p>Promotes patient involvement/independence; provides opportunity for compromise and may enhance cooperation with regimen. When patient participates in setting goals, there is a sense of investment that encourages cooperation and willingness to follow through with the program.</p>
<p>Assess availability/use of support systems. Identify additional resources as appropriate.</p>	<p>Access to/proper use of helpful resources can assist patient in meeting treatment goals and provide purpose for living. Presence of caring, empathic family/SO(s) can help patient in process of recovery.</p>
<p>Determine potential problems that may/do interfere with treatment, including lack of financial/personal resources, unavailability of providers. Assess level of anxiety, locus of control, sense of powerlessness.</p>	<p>Many factors may be involved in behavior that is disruptive to the treatment regimen (e.g., fear of hospitalization/treatment; denial of situation consequences; suspicion about healthcare system; physical factors, such as pain, hypoxemia, chemical imbalance).</p>
<p>Note length of illness/prognosis.</p>	<p>Patients tend to become passive and dependent in long-term, debilitating illness.</p>
<p>Listen /to/ Active-Listen patient's reports and comments.</p>	<p>Conveys message of concern, belief in individual's capabilities to resolve situation in positive manner.</p>
<p>Develop a system for self-monitoring. Share data pertinent to patient's condition, e.g., laboratory results, blood pressure (BP) readings.</p>	<p>Provides a sense of control; enables patient to follow own progress and make informal choices.</p>
<p>Have same personnel care for patient as much as possible.</p>	<p>Enables relationship to develop in which patient can begin to trust/participate in care.</p>
<p>Accept patient's choice/point of view, even if it appears to be self-destructive, e.g., decision to continue smoking.</p>	<p>Patient has the right to make own decisions, and acceptance may give a sense of control, which can help patient look more clearly at consequences. Confrontation is not beneficial and may actually be detrimental to future cooperation and goal achievement.</p>
<p>Be aware of own/caregiver's response to patient's treatment choices (e.g., refusal of blood or chemotherapy, living will).</p>	<p>Negative feelings regarding these choices may create power struggles and be expressed in judgmental behaviors that block or interfere with patient's wishes, comfort, and/or care. <i>Note:</i> If resolution cannot be found, providers have the right to terminate their services with appropriate notice.</p>



**NURSING DIAGNOSIS: Violence, risk for self-directed/other-directed**

**Risk factors may include**

History of violence against others; violent antisocial behavior, indirect (tearing of clothes, temper tantrum, yelling, throwing things); childhood abuse; witnessing family violence; cruelty to animals, firesetting  
Attempt to deal with the threat to self-concept that illness can represent  
Antisocial character; catatonic/manic excitement; panic states; rage reactions; psychotic symptomatology  
Suicidal ideation/behavior, depression; impulsivity  
Hormonal imbalance; neurological impairment, such as temporal lobe epilepsy; toxic reactions to medication  
Negative role modeling; developmental crisis

**[Possible indicators]**

Suspicion of others, paranoid ideation, delusions, hallucinations  
Expressed intent or desire to harm self/others (directly or indirectly); hostile verbalizations; plan and possession of/access to destructive means  
Body language: rigid posture, clenched fists, facial expressions  
Increased motor activity, excitement, irritability, agitation  
Overt and aggressive acts; self-destructive behavior  
Substance abuse/withdrawal

**DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:**

**Impulse Control (NOC)**

Acknowledge realities of the situation.  
Verbalize understanding of reason(s) for behavior/precipitating factors.  
Express increased self-concept.  
Demonstrate self-control, as evidenced by relaxed posture, nonviolent behavior.

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Mood Management (NIC)</b></p> <p><b>Independent</b></p> <p>Observe for early signs of distress.</p> <p>Maintain straightforward communication and assist patient to learn assertive rather than manipulative, nonassertive/aggressive behavior.</p> <p>Help patient identify more adequate solutions/behaviors (e.g., motor activities/exercise). Provide directions for actions patient can take.</p> <p>Give as much autonomy as is possible in the situation.</p>	<p>Irritability, pacing, shouting/cursing, lack of cooperation, and demanding behavior all may be signs of increasing anxiety.</p> <p>Avoids reinforcing manipulative behavior and enhances positive interactions with others, accomplishing the goal of getting needs met in acceptable ways.</p> <p>Promotes release of energies in acceptable ways.</p> <p>Enhances feelings of power and control in a situation in which many things are not within individual's control.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Mood Management (NIC)</b></p> <p><b>Independent</b></p> <p>Monitor for suicidal/homicidal intent, e.g., morbid or anxious feelings while with patient, thoughts expressed by/warning from patient, “It doesn’t matter, I’d be better off dead”; mood swings, putting affairs in order, previous suicide attempt.</p> <p>Assess suicidal intent (1–10 scale) by asking directly if patient is thinking of killing self, has plan, means, and so on.</p> <p>Acknowledge reality of suicide/homicide as an option. Discuss consequences of actions if patient were to follow through on intent. Ask how it will help patient resolve problems.</p> <p>Accept patient’s anger without reacting on an emotional basis.</p> <p>Remain calm and state limits on behavior in a firm manner. Be truthful and nonjudgmental.</p> <p>Assume that patient has control and is responsible for own behavior.</p> <p>Identify conditions that may interfere with ability to control own behavior.</p>	<p>Indicators of need for further assessment, evaluation, and intervention/psychiatric care.</p> <p>Provides guidelines for necessity/urgency of interventions. Direct questioning is most helpful when done in a caring, concerned manner.</p> <p>Patient is often focused on suicide (or homicide) as the “only” option, and this response provides an opening to look at and discuss other options. <i>Note:</i> Be aware of own responsibility under Tarasoff rule to warn possible victim(s) when patient is expressing homicidal ideation.</p> <p>Responding with anger is not helpful in resolving the situation and may result in escalating patient’s behavior.</p> <p>Understanding that helplessness and fear underlie this behavior can be helpful.</p> <p>Often enables the individual to exercise control. <i>Note:</i> When violent behavior is the result of drugs, patient may not be able to respond appropriately.</p> <p>Acute or chronic brain syndrome, drug-induced or postsurgical confusion may precipitate violent behavior that is difficult to control.</p>
<p><b>Environmental Management: Violence Prevention (NIC)</b></p> <p>Provide protection within the environment, e.g., constant observation, removal of objects that might be used to harm self/others.</p> <p>Tell patient to “stop.”</p> <p>Use an organized team approach when necessary to subdue patient with force. Tell patient clearly and concisely what is happening.</p> <p>Hold patient; place in restraints or seclusion if necessary. Do so in a calm, positive, nonstimulating/nonpunitive manner.</p>	<p>May need more structure to maintain control until own internal locus of control is regained.</p> <p>May be sufficient to help patient control own actions when exhibiting hostile actions. <i>Note:</i> Patient is often afraid of own actions and wants staff to set limits.</p> <p>Knowing and practicing these actions before they are needed helps prevent untoward problems. Keeping patient informed can help patient to regain internal control.</p> <p>As a last resort, physical restraint may be necessary while patient regains control. <i>Note:</i> These measures are meant to protect patient, not punish the behavior.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Environmental Management: Violence Prevention (NIC)</b></p> <p><b>Independent</b></p> <p>Apply and adjust restraint devices properly.</p> <p>Document precise reason for restraints, actions taken. Check restraints frequently per facility protocol, each time documenting the condition and how long the restraints are used.</p> <p><b>Collaborative</b></p> <p>Refer to psychiatric resource(s), e.g., psychiatric clinical nurse specialist, psychiatrist, psychologist, social worker, classes, such as anger management.</p> <p>Administer medications, e.g., antianxiety/antipsychotic agents, sedatives, narcotics.</p>	<p>It is important to maintain body alignment and patient safety and comfort.</p> <p>Restraints are to be used for very specific reasons, which need to be clearly documented to avoid overuse or misuse.</p> <p>More in-depth assistance may be needed to deal with patient and defuse situation. Learning new ways to deal with feelings can provide opportunity for individual to manage life in a more optimal way.</p> <p>May be indicated to quiet/control behavior. <i>Note:</i> May need to be withheld if they are suspected to be the cause of/contribute to the behavior.</p>

<p><b>NURSING DIAGNOSIS: Post-Trauma Syndrome</b></p> <p><b>May be related to</b></p> <p>Events outside the range of usual human experience: disasters (e.g., floods, earthquakes, tornadoes, airplane crashes), wars, epidemics, rape, incest, assault, torture, catastrophic illness or accident, being held hostage; physical/psychosocial abuse</p> <p><b>Possibly evidenced by</b></p> <p>Reexperiencing traumatic event (may be identified in cognitive, affective, and/or sensory/motor activities, e.g., flashbacks, intrusive thoughts, repetitive dreams or nightmares, excessive verbalization of the traumatic event, verbalization of survival guilt or guilt about behavior required for survival)</p> <p>Altered lifestyle (self-destructiveness); loss of interest in usual activities; loss of feeling of intimacy/sexuality; development of phobia; poor impulse control/irritability and explosiveness</p> <p>Disturbance of mood, e.g., depression, anxiety, embarrassment, fear, self-blame, low self-esteem; hypervigilant; exaggerated startle response</p> <p>Cognitive disruption: confusion, loss of memory/concentration, indecisiveness</p> <p><b>DESIRED OUTCOMES/EVALUATION CRITERIA—PATIENT WILL:</b></p> <p><b>Coping (NOC)</b></p> <p>Verbalize reduced anxiety/fear.</p> <p>Demonstrate ability to deal with emotional reactions in an individually appropriate manner.</p> <p>Express own feelings/reactions; avoid projection.</p> <p>Demonstrate appropriate changes in lifestyle/getting support from SO as needed.</p> <p>Participate in plans for follow-up care/counseling.</p>
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ACTIONS/INTERVENTIONS	RATIONALE
<p><b>Counseling (NIC)</b></p> <p><b>Independent</b></p> <p>Determine when traumatic event(s) occurred: present or past.</p> <p>Assess physical trauma, if present, and individual reaction to occurrence, e.g., physical symptoms such as numbness, headache, tightness in chest, and psychological responses of anger, shock, acute anxiety, confusion, denial.</p> <p>Evaluate behavior (e.g., calm or agitated, excited/hysterical; inappropriate laughter, crying), expressions of disbelief and/or self-blame.</p> <p>Note ethnic background/cultural and religious perceptions and beliefs about the event.</p> <p>Assess signs/stage of grieving.</p> <p>Tell patient that painful emotional reactions are normal. Phrase this information in neutral terms: “You may or may not experience . . .”</p> <p>Discuss things patient can do to feel better, e.g., physical exercise alternated with relaxation; keeping busy with normal activities; talking to others; acknowledging that it is all right to feel upset; writing about the experience in a journal; being kind to self.</p> <p>Assist with learning stress management techniques.</p> <p>Identify supportive persons for patient.</p> <p>Note signs of severe/prolonged depression; frequency of flashbacks/nightmares; presence of chronic pain, somatic complaints.</p> <p>Help patient identify factors that may have created a vulnerable situation/increased likelihood for event.</p>	<p>Manifestations of acute and chronic posttrauma responses may require different interventions. <i>Note:</i> Event may encompass many forms of trauma, including the diagnosis of life-threatening illness.</p> <p>Provides information with which to develop plan of care, make informed choices.</p> <p>Indicators of extent of individual response to traumatic incident and degree of disorganization.</p> <p>May influence patient’s response to what has happened, e.g., may believe it is retribution from God.</p> <p>Patient may be suffering from sense of loss of self and/or others.</p> <p>Understanding that experiencing these uncomfortable feelings is not unusual after traumatic event may reduce patient’s anxiety/fear of “going crazy” and enhance coping.</p> <p>Enhances sense of control and helps patient achieve resolution of uncomfortable feelings. Often when patient begins these activities within the first 24 hr of the event, further therapy may not be required.</p> <p>Promotes sense of control and ability to handle existing problems.</p> <p>Having positive support systems can help patient reach optimal recovery.</p> <p>If patient did not deal with trauma when it occurred, behavioral manifestations may reveal extent of problem in the present.</p> <p>Even though individual may not be responsible for what has happened, he or she may have created an atmosphere in which negative things occurred. Changes in behaviors/lifestyle may decrease potential for recurrence.</p>

ACTIONS/INTERVENTIONS	RATIONALE
<p data-bbox="235 304 430 336"><b>Counseling (NIC)</b></p> <p data-bbox="235 352 406 384"><b>Collaborative</b></p> <p data-bbox="235 401 787 577">Refer to support groups, counselors/therapists for further therapy, e.g., psychotherapy (in conjunction with medications), implosive therapy, flooding, hypnosis, eye movement desensitization and reprocessing (EMDR), Rolfing, memory work, or cognitive restructuring, as indicated.</p>	<p data-bbox="820 401 1388 514">When posttrauma response has become chronic, patient may need more in-depth assistance from sensitive, trained individuals who are skilled in dealing with these problems.</p>

**POTENTIAL CONSIDERATIONS**

Refer to primary diagnosis for postdischarge concerns.